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COORDINATING HOSPITAL AND COMMUNITY WORK ADJUSTMENT SERVICES. FINAL REPORT.

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CAMARILLO STATE HOSPITAL, CALIF.
JEWISH VOCATIONAL SERVICE, LOS ANGELES

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THE GOALS OF THIS STUDY WERE TO USE WORK TO HELP PATIENTS LEAVE THE CAMARILLO STATE HOSPITAL SOONER, BECOME A PART OF THE COMMUNITY, AND BECOME SELF-SUPPORTING. THE PROJECT SELECTED 146 SCHIZOPHRENIC MALES WHO HAD A HISTORY OF POOR WORK ADJUSTMENT. AS PART OF THE TREATMENT, THE MEN WERE PLACED IN THE HOSPITAL BAKERY. AFTER ADJUSTMENT TO THE WORK SITUATION IN THE BAKERY AND AFTER GROUP AND INDIVIDUAL COUNSELING, THE MEN WERE RELEASED TO THE COMMUNITY. THEY WERE EMPLOYED BY THE HANDCRAFT INDUSTRIES OF THE JEWISH VOCATIONAL SERVICE AS THE SECOND PHASE OF THE PROJECT TO INCREASE THEIR LEVEL OF FUNCTIONING IN AND ADJUSTMENT TO A WORK SITUATION. DETAILS OF THE PROBLEMS ENCOUNTERED WITHIN THE HOSPITAL BAKERY AND OTHER DEPARTMENTS, AND OF ARRANGING COMMUNITY LIVING FACILITIES ARE GIVEN. OF THE MEN INVOLVED IN THE PROJECT, 89 LEFT THE HOSPITAL, 63 STAYED OUT FOR 6 MONTHS, AND 31 BECAME SELF-SUPPORTING. THE PROJECT IS OFFERED AS A MODEL FOR VOCATIONAL REHABILITATION THROUGH AGENCY COOPERATION AND HOSPITAL PROGRAMS. (NS)

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By

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Morris Grumer
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January 1967

FINAL REPORT OF A JOINT STUDY BY CAMARILLO STATE HOSPITAL AND THE JEWISH VOCATIONAL SERVICE OF LOS ANGELES.

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We wish to acknowledge our appreciation to the many staff members from the hospital and from many community facilities who cooperated with this project. The list would be so long that no attempt will be made to name them. However, we do want to honor three agencies whose consistent effort played essential roles in the conduct of the project.

Jewish Free Loan Association

The Portals House, Inc.

Bureau of Social Work,
Westside Office

PREFACE

Camarillo State Hospital has had for many years an abiding interest in research in the areas of treatment and rehabilitation of schizophrenic patients, who form such a large portion of the population of our State Hospital. We are always eager to find ways of working more effectively with other agencies, both public and private, because of our conviction that only through such cooperation can patients be helped to achieve their full potential for functioning in the community.

It would be less than candid to give the impression that the project ran smoothly at all times. It must be recognized that the hospital exists primarily as a treatment center, and it was therefore faced with many of the problems that arise in a service oriented setting which involves itself in research. However, we welcomed the opportunity to work so closely with the Jewish Vocational Service. We want to express here our appreciation to the other community agencies who contributed materially to the project, particularly the Jewish Free Loan Association and the Portals House, Inc.

There was recently initiated an agreement between this hospital and the State Department of Rehabilitation providing for a substantial expansion in the Vocational Rehabilitation Services available to patients. The agreement represents in significant part an expansion of the program developed in the project.

LOUIS R. NASH, M.D.
SUPERINTENDENT-MEDICAL DIRECTOR
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PREFACE

Interest in those with special vocational problems has characterized the program of the Jewish Vocational Service since its inception some 35 years ago. While mentally ill persons have always been served by the agency, it developed heightened interest and concern for this group, as part of the increased concern of the total community, following the development of improved understanding and treatment techniques, some fifteen years ago. One facility developed by the agency to serve the emotionally ill is Handcraft Industries, a transitional rehabilitation workshop.

Handcraft has been serving former State mental hospital patients from Metropolitan, Camarillo and Pacific, as well as those from private hospitals, such as Gateways and Resthaven. When the opportunity came to extend its services to reach patients earlier and to develop closer working relationships with Camarillo, the agency was eager to participate.

Involvement in this project resulted not only in an increase in the number of persons served, but created certain changes in the manner of service. The fact that patients entered the workshop directly from the hospital resulted in our staff becoming more intimately involved with a host of "non-work" problems in the lives of these patients.

We anticipate that the experience our agency has had with this project will increase its effectiveness in serving the emotionally disturbed. This experience has served to stimulate our Board to seek additional ways to enhance the partnership between the large public facilities and the smaller private agency.

IRWIN H. GOLDENBERG
President
Jewish Vocational Service

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I RATIONALE GOALS AND HISTORY

The modern mental hospital, according to the Joint Commission on Mental Illness and Health (1), should be an integrated portion of a treatment and rehabilitation continuum, having its focus in the patient's own community. The successful rehabilitation of the hospitalized psychiatric patient, therefore, can best be accomplished by a careful coordination of hospital and community resources. A similar conclusion is presented as the first recommendation growing out of the study conducted by the Jewish Vocational Service of Essex County in cooperation with Overbrook Hospital and the New Jersey Rehabilitation Commission (2).

In a monograph of the National Institute of Mental Health (3), the following observations are made: "For many years in America any patient able to work was expected to do so in the service of the hospital...The hospitals reached an unhappy equilibrium where a great deal of inefficient patient labor was necessary to keep a hospital going...Revulsion over the abuses of this system has led to a complete about-face (to the point where)... the potentially beneficial value of the work under proper clinical supervision is easily lost from view...patients must be able to work productively before they can adjust successfully in the extra-hospital world, a number of hospitals have begun programs to retrain patients in work habits and skills under conditions closely simulating those in the world outside."

Mindful of these conditions, we developed a project which had as its goals: 1) to use work as an instrument to help patients leave the hospital sooner, 2) to insure their tenure in the community, and 3) to raise their level of instrumental functioning. To accomplish these goals two facilities were utilized: the bakery within the hospital and Handcraft Industries, a community rehabilitation workshop of the Jewish Vocational Service. The program

of Handcraft in working with psychiatric patients is described in a paper by its director (4).

One of the purposes of this project was to change the traditional patient work assignment from being part of the custodial-maintenance system toward seeing it as part of the treatment-rehabilitation continuum.

The second purpose was the desire to develop a close working relationship between the hospital and an existing community rehabilitation facility. One important intermediate goal was to see whether it is possible to increase the proportion of the referred patients who actually utilized a community resource. We were particularly aware of the results of one well designed and carefully carried out study (5) between the Rockland State Hospital and Altro Workshop in New York in which only a small proportion of those who were referred by the hospital actually entered the Altro program. We wanted to see whether this gap could be bridged by using various techniques not employed in that study.

Handcraft Industries had become interested in involving itself more closely with a group of post-mental hospital patients for whom a pre-vocational evaluation and preparation for work could be provided while the patient was still in the hospital. This experience would give Handcraft a vocational evaluation of the patient at the point at which he entered the community workshop. Basically, Handcraft felt that this pre-vocational exposure might prepare the patient to make better use of the services which Handcraft had to offer.

Part of the background that perhaps goes without saying is the concern of this hospital and other hospitals with the high return rate of patients--particularly during the early months after leaving the hospital--and concern with the experiences patients were having in the community during this period. This project can be seen as one attempt to do something about this problem; namely, to provide services which would be continuous, including the last months in the hospital and the first months in the community.

The planning of this project goes back to 1960 when many people felt a need for expanding vocational rehabilitation services for mental hospital patients. People from the hospital, from the Jewish Vocational Service, from the State Department of Vocational Rehabilitation, and the Regional Office of the Vocational Rehabilitation Administration worked together in planning this project.

Originally a contract workshop on the hospital grounds had been proposed. However, it was felt that this was not necessary, because a great deal of real work already existed in the hospital which could be easily used for rehabilitation. This would eliminate the effort necessary to establish and maintain a contract workshop, including finding space, getting machinery, negotiating contracts for work, transporting the raw material to the hospital and then transporting the finished product out of the hospital. All of this activity does not in itself contribute to patient rehabilitation. It is staff work that needs to be done to provide a work opportunity for patients. It was felt that using existing work would have greater applicability to institutions and hospitals everywhere, all of which have a variety of work activities but may not have sub-contract possibilities available to them.

A controlled study was originally submitted to the Vocational Rehabilitation Administration involving a number of initially comparable groups of patients to be assigned to different combinations of services so that conclusions might be drawn as to the relative values of the different services in patient rehabilitation. V.R.A. suggested instead a demonstration project providing services to a defined group of patients. The present project was then submitted and approved.

A grant was awarded by the Vocational Rehabilitation Administration to Camarillo State Hospital to make this demonstration possible. The involvement of Handcraft Industries was accomplished by a contract between the hospital and the Jewish Vocational Service to pay for additional personnel assigned to the project.

II THE HOSPITAL PHASE

THE PROJECT UNIT

Camarillo State Hospital is composed of six divisions: four regular psychiatric (2 male, 2 female), a children's and a medical-surgical division. Each division in the hospital is semi-autonomous with its own assistant superintendent and staff.

The project was originally designed to use one unit in each of the two male divisions which include 28 units (wards). If each division had its own project unit, the transfer of a project patient from any unit to a project unit would be a simple matter within a division, as compared to inter-divisional transfer which necessitates administration procedures. One hospital unit in each male division was selected because of its previously demonstrated cooperation with hospital industrial therapy programs. An orientation program was developed with the staff of one of the project units. This included visits to the hospital bakery and the community workshop. The first patient group involved in the project was housed on this unit.

Our experience in developing this project unit suggested that a second project unit would not be desirable for several reasons. The hospital social service department could not permit the social worker, who was assigned one-half time to the project, to work on units in different divisions since it was department practice to assign workers to a single division. The alternative of having two social workers devoting one-fourth of their time to the project was considered to be impractical. The close relationship which was needed between the project staff and the unit treatment team could best be developed by confining the project to a single unit. In addition, it was felt that housing all project participants on a single unit would help develop a feeling of group membership and

identification among the clients. The two division superintendents agreed with the proposal that a single unit be used to serve both divisions. Unit 6A was selected. However, some physicians preferred to keep "their" patients and objected to transferring patients to the project unit. They felt that they knew the patient better and consequently could provide better treatment.

In those few instances when the project staff agreed to this departure from project procedure, difficulties ensued. The project staff could not attend the team meetings on the units with one or two project patients because this was an uneconomical use of time. Thus, leave plans and treatment strategies could not be coordinated. The principal difficulties encountered with patients housed on units other than the project unit was the scheduling of work and meal hours, lack of identification with the project as a whole, and the absence of a close relationship between the project staff and the unit treatment team members.

The hospital administration also agreed that so far as possible the staff of Unit 6A would not be transferred to other units during the lifetime of the project.

Due to the orientation of the unit team and their involvement with the project, there was little problem in securing an adequate flow of referrals from this unit. During the first three months of the project more patients from Unit 6A were referred than were referred by all of the other male units. Another reason for the large number of referrals from 6A is that non-project participants on the unit were able to learn of the project because of the daily contacts thay had with those in the project. There were generally 15 or 16 project members on this 90-bed unit. Whatever the reasons, throughout the entire lifetime of the project, there continued to be a markedly larger number of patients admitted from 6A than from all of the other units. Forty patients on the project were referred from the project unit and the remaining participants (106) were from the 27 other male units.

For purposes of efficiency it was decided to seek referrals from one unit at a time, alternating between divisions. In this manner contact could be maintained with each referring unit, and the referring staff kept informed about the progress of their referrals.

The project unit personnel played an essential role in the conduct of the project. Because of this the project staff recognized the importance of becoming thoroughly familiar with the operations and problems of the unit. As part of this process, a series of individual interviews were held with the physician to discuss project goals and proposed methods, and project staff spent several days on the unit talking with the unit personnel about the project.

Each member of the unit treatment team, including the physician, was invited to observe the operation of the bakery and of the community workshop, and subsequently to see the commercial hotel where some of the project participants were housed. This orientation was effective in helping the treatment team to understand the project better. This encouraged more involvement and support for the project and its clients. The orientation program was a continuous process involving updating unit personnel and orienting new personnel on the unit. In addition, project unit staff was involved in developing changes in project procedure.

A close relationship between the project and unit staffs required clear communication channels. The project staff attended unit team meetings to discuss cases and developments within the project. This served to keep project staff informed on unit problems and informed the unit team of the project's progress and problems. There was continuous communication between individual personnel of the unit, project and bakery staff. For example, when problems arose in the bakery, a project staff member contacted the unit physician or nursing supervisor to inform or consult with him regarding problems or changes in patient behavior. Conversely, unit personnel maintained contact with project staff regarding changes in patient behavior observed by them.

The unit was often asked to support the discipline necessary for working in the bakery. When a patient did not report to work or behaved in an unacceptable way in the bakery, the physician might suspend the patient's ground privilege card. This was seen as one way of demonstrating to the patient that his work was regarded by the physician as an essential part of his treatment in the hospital. The unit staff also helped patients to get to work on time and to maintain their personal grooming.

It was impressed upon the patient that his hospital work behavior was closely related to his anticipated vocational adjustment in the community. All participants were informed that during work hours they were expected to work without interruptions for recreation, other therapies, or other activities. The staff felt that it was essential to minimize any interference with the vocational rehabilitation program which the project had developed for the patient.

Coordination between the personnel of 6A, the project staff and the bakery was essential to the operation of this project. The functions and internal structure of the project unit were not altered or changed. What was done was to coordinate living and work areas towards the common goal of rehabilitating the patient. In this manner, patients visualize their unit and work experiences not as isolated events but as two interdependent experiences involved in their total rehabilitation program.

MODIFYING THE WORK SETTING

The bakery was chosen as the hospital work setting because it was a fairly typical hospital industry and had several characteristics making it particularly suitable for the project. It was located in a large, one-story building within a complex of other shops and industries. Although there was a great deal of bakery equipment, it was obsolete and great reliance was placed on human help as in other large, public institutions. The bakery provided a number of different work activities offering opportunity for a variety of work experiences. These included a hierarchy of activities ranging from

low-level, virtually unsupervised duties, to more demanding, more closely supervised tasks, often involving a degree of judgement and some skill. Examples of specific tasks included counting and sorting bakery items, disassembling, cleaning and re-assembling machines, breaking eggs, loading of storage bins, loading and unloading the ovens, placing dough patties on pans, tending the bread machine, wrapping bread and frosting cakes.

The size of the bakery is such that its needs could be adequately met by 15 or 16 patient helpers which is the number who can be served by one counsellor. In selecting the bakery as the project site we were also mindful of the fact that the bakers appeared to be receptive to the idea of using work to help patients in their rehabilitation. Seven bakers were regularly employed in this work area. The bakery operated seven days a week and typically there were four or five bakers at work on any given day. Previous to the project some 20 to 25 patients were assigned to work in the bakery but only 10 or 12 would report for work. As was characteristic of most patient work, attendance was irregular, some patients working very short hours and a few working very long hours. Work was frequently interrupted for other activities. There was a high turnover of patients and the bakers relied on a few "permanent" patient helpers.

Traditionally, employees who are not members of the recognized treatment team were hired for their trade skills. The bakers were hired as bakers, not as therapists. The entire reward system for them was in terms of their production of baked goods--not in terms of rehabilitation of patients. Therefore, it was not surprising to find that patients were used to help meet production requirements with little thought given to using the work activity for its rehabilitation values.

In the preparatory work for the project, some contact had been made with the bakers to evaluate their willingness to accept the project. When the project began, steps were taken to further acquaint the bakers with project goals. The project's philosophy concerning the role of work in the rehabilitation process was discussed with them and they were oriented toward their roles in helping

the project meet its goals for the patients. Arrangements were made for the bakers to visit the unit on which the project patients lived. This was the first opportunity they had for such a visit. Trips were arranged to Handcraft Industries in Hollywood. Weekly meetings were set up at which specific patients' needs, problems and performance were reviewed.

In order to gain acceptance by the bakers and to obtain a better picture of the work activities, the project supervisor worked in the bakery, in the early weeks, rotating through every work area. The experience enabled him to write job descriptions and to make time studies where applicable. Working in the bakery wearing work clothes contributed toward greater acceptance of the project supervisor by the bakers.

Although the bakers cooperated in making the various changes and adjustments required for the project there were some difficulties in having a baker assigned as foreman over the patient-workers. Almost a year passed before the Food Services Administration was able to designate a foreman. During this period the project supervisor was almost wholly responsible for the supervision of the patient-workers in the bakery. This was reasonably effective while few project patients were in the community. However, as more patients completed the hospital phase of the rehabilitation program and were moved into the community, this arrangement became increasingly difficult because the project supervisor had to spend more and more time with the increasing number of patients who were out of the hospital.

In the second half of the project, when sicker and less productive patients were being accepted, there were some changes in the attitude of some of the bakers. Those bakers who had been enthusiastic at the outset remained so. However, those who were originally less than enthusiastic became quite discouraged with the type of person then coming into the bakery and provided very little training to the patient to do specific jobs, simply because these patients required more time than the original subjects.

The method of assigning patients to the various tasks in the bakery was not constant during the life of the project. It was changed in response to experience and problems which grew out of each of the methods. While the particular problems arising from the assignment of work in this project are specific to the work setting and the hospital industry involved, they may still have some similarity to problems which are likely to arise in other settings. We will, therefore, describe our experience in some detail.

Following a "break-in" period to help the patient ease into the structured work situation, the first approach involved the establishment of three work levels. Level One focused on work discipline. Here emphasis was placed upon helping the patient get to work on time, on proper grooming and on staying in the work area for a three-hour period. The work performed was largely cleaning, sweeping and mopping floors, chipping dry dough, cleaning baseboards and scraping bakery tables. The second level was designed to increase work tolerance. The patient was assigned a longer work day. He was given more complex tasks involving some judgement, including the cleaning, breakdown and reassembly of machines. He was also assigned to some production activities. Emphasis was placed upon encouraging the patient to complete each task and to increase his functioning level. On the third work level the patient was expected to work the same daily schedule as his supervising baker, put in a full six hour work day and become accustomed to increasing work pressures and production demands as well as general "assembly line" procedures. Assignments covered the range of work activities found in any commercial type bakery from assembling the ingredients brought from the stockroom, to assisting in the mixing of the dough, to tending the large bread ovens, to assisting bakers in the creation of French pastry.

As the first patients moved through the bakery, the project staff was evaluating this approach to work assignments. It was found that most patients entering the project came from other industrial therapy assignments and were capable of working a six-hour day from the start. Some patients were immediately capable of more demanding

work. In addition, it was found that the entire work crew was needed in the morning for the actual baking process. This meant that people in the advanced work level were free and available for cleaning activity in the afternoon. As a result the original method of work assignment was modified to one of assigning individual patients to individual bakers. The project staff attempted to match the patient to the baker who best met the patient's needs. The patient who needed firm supervision was assigned to a baker who could provide this. Patients who had difficulty in working under stress would be given a work assignment which would expose them to such a condition. For example, working with the crew unloading the bread oven. The patient's handling of these situations could then be considered with him during the counseling sessions. This approach to work assignment could not be maintained since the demands of the production process made it difficult to maintain the "one patient, one baker" assignment.

When the patient came to work in the morning, he had no specific job assignment but the bakers would select, each day, the patients with whom they were to work. When the assignment was completed, patients were assigned to other available tasks, resulting in the performance of a variety of tasks each day. This retained certain positive aspects of the earlier methods: jobs were still graded, tasks were assigned according to ability, and patients needing help with special experiences were assigned to selected bakers.

We have discussed problems arising in the assignment of work and approaches used in meeting these problems. Other areas in which the project faced varying degrees of difficulty included 1) limitations of bakers' understanding of patients' capacities, 2) bakers' concern over loss of trained patient-helpers, 3) arranging a full work day, 4) continuity of work, 5) assignment of foreman over patient workers.

One of the most persistent problems was the bakers' attitudes toward patients' capacities to meet work demands. Generally, mental hospitals' work assignments are made and carried out on a permissive basis, patients working as much or as little as they choose. Little demand for

quality or quantity of production is made upon the patient. In spite of efforts to orient the bakers to a different concept, it was difficult to get the bakers to accept the validity of making realistic demands for performance on the patients. However, some changes were noted and some of the bakers were eventually able to make more realistic demands of the patients.

The bakers were concerned over the loss of project patients trained to the point where they could work independently on various jobs in the bakery. At that point, the patients' general functioning level improved enough to permit them to leave the hospital. The individual baker felt himself to be in a position of constantly having to train patient help. Prior to the project, several patient-helpers had worked in the bakery for many years. This type of patient was most useful in meeting production demands. On several occasions the bakers requested that a cadre of three or four long-term patients be kept in the bakery. It was pointed out that this was not really fair to the patients but it was difficult to change these attitudes. This difference in approach persisted to the end of the project and there was a return to old practices when project staff was withdrawn from the bakery.

The project staff originally anticipated that patients would work up to a full eight-hour day in the bakery. In actuality, this was not possible due to patients' eating schedules and various requirements on the project unit, as well as limited production demands. The work schedule of the bakers was such that they began production an hour and a half before any of the patient helpers could arrive at their work station. This conflict in schedules meant that an eight-hour day could never be achieved for the patients.

Because the bakery was subject to periods of peak production demands followed by periods of minimal or no production, it was difficult to maintain an even continuity of work. This resulted in periods when it was difficult to find adequate work activity for all of the patients. To handle this problem, some small cleaning jobs were created but the staff was not always satisfied with the amount of work activity which was available.

In the development of the project design, discussions were held with the food services administrator in which an agreement was reached providing for the assignment of the chief baker to serve one half-time tour as foreman of the patient work in the bakery. However, because the chief baker was due to retire, the Food Service Administration decided to assign one of the other bakers to this responsibility. The project supervisor, who had been filling in as foreman, worked closely with the baker until it was felt he could assume responsibility for this phase of the project. It soon became clear that this arrangement was faulty because, even though the baker had been officially relieved of his production duties, he was still required to continue to perform as a baker. Had the chief baker been assigned the supervisory position as originally proposed, it might have been more successful, since traditionally the chief baker is not required to bake. The two jobs expected of the foreman became quite strenuous and after eight months he asked to be relieved of his responsibilities with the project and officially confined to his original baking duties. The project supervisor and project counselor were compelled to play the role of foreman.

The project demonstrated that it was possible to use a work area as a work adjustment setting; that patients were able to cope with and benefit from a structured work setting. Further, this program was conducted without any sacrifice in productivity. In fact, the bakery produced a substantially larger number of different items after the project was underway.

However, while the project was generally successful during its operation in having some of the bakers see patient-workers differently, fundamentally the project was not successful in creating permanent changes in the bakers' basic approach to patient-helpers. The new ways were not integrated into food service operations. All went well as long as the project staff were directly in the picture. When they left, the bakery reverted to its traditional ways. No special rewards were offered for contributions to patient rehabilitation. Understandably, they again sought a cadre of long-term patient-workers who could serve as "permanent" helpers.

SELECTION OF PATIENTS

The criteria for the selection of subjects was designed to include a sample of a major difficult portion of the state hospital population, specifically schizophrenic men with moderate or long hospitalization and a very poor history of vocational adjustment. The criteria in the project proposal follow:

Age - 18 to 45 years. This range was selected to eliminate legal and social problems around placement in industry of those under 18 and general industrial attitudes concerning workers over 45 years.

Sex - Men only. Women were excluded from the project to increase the homogeneity of the sample and to simplify the physical arrangements in the hospital industry. Women in this age group, for a variety of reasons, unrelated to their psychiatric condition, may withdraw from the labor market.

Residence - Easy commutation distance to Handcraft Industries in Hollywood.

Psychiatric Classification - Schizophrenia - any type, not complicated by gross physical handicaps or other conditions affecting employability.

Length of Hospital Residence (at time of referral to project) - 3 to 24 months. A residence of less than three months was considered wasteful for selection for the project since the likelihood of imminent discharge from the hospital allows insufficient opportunity for working with the patient and many such patients return to their previous jobs. Hospitalization of over 24 months was considered to be too chronic for inclusion in this demonstration.

Prognosis - Likely to be able to leave the hospital within six to eight months; to be determined by the ward physician.

Work Background - In need of vocational rehabilitation counseling and work adjustment experience. Fair to good prospect for placement in competitive industry following hospitalization and the vocational rehabilitative services of the project.

These criteria for selection of subjects were designed to make the sample adequate in size, as homogeneous as possible, and appropriate to the purpose of the project.

During the course of the project, length of hospital residence was eliminated as a criterion because experience demonstrated that there were patients with less than three months of hospitalization who were in need of and apparently able to participate in a vocational rehabilitation program. At the other extreme, early success with patients hospitalized up to two years encouraged the investigators to include those with longer periods of hospitalization.

Our experience showed that a number of subjects selected for the project were already involved in other programs leading to release. Because of difficulties which this created in terms of the patient's actual availability and because of our desire to avoid competition for "desirable patients", and in order to serve those not receiving other specialized services, "not involved in other hospital programs leading to release" was made a condition for selection.

The first step toward obtaining suitable referrals involved informing staff members on a few male units of the existence of the project, its objectives and the criteria for selection. A conference was arranged with the unit physician to brief him on the project and his cooperation was obtained to screen patients on his unit. The project supervisor and the unit charge* reviewed the patient roster to find potentially eligible subjects. The project social worker then obtained the medical records to determine whether there were any gross reasons precluding eligibility.

*nursing service day shift supervisor

The prospective subject's history was then evaluated by the project team to determine his need for vocational rehabilitation services. A number of signs were used to establish such need: inability to find employment; repeated failure to hold employment; a history limited to casual work.

However, the fact of need for service did not by itself qualify one for selection. There had to be some indication of ability to profit from vocational rehabilitation help. This might be demonstrated either by the presence of even limited abilities or the absence of significant handicaps. Patients should have at least dull-normal general intellectual ability so as to rule out the confounding effects of mental retardation. They must not have symptoms of a degree of severity requiring an unreasonably high amount of supervision. There should not be gross behavior symptoms affecting employability such as alcoholism, overt sex deviation, history of criminal behavior, drug addictions, and impulsive, aggressive acting out behavior.

However, a history of such behavior did not automatically exclude the patient. If there was an absence of such behavior during a significant period of time or if the behavior was judged to have been more situational than characterological, even patients with such a negative history were considered.

Following this review by the project team the names of patients who were agreed upon as suitable for the program were presented to the unit physician. The patients approved by him were then discussed at the unit team meeting when final selection was made of those who would be referred to the project counselor. This step served the dual purpose of giving the project staff the benefit of the greater understanding of the unit staff, those who knew the patient best, and of helping to involve key personnel in the success functioning of the project.

During the first interview the project counselor acquainted the patient with the general purpose of the project and oriented him to its program. He was given a week to "think it over" and was advised to discuss the program with his unit technicians and perhaps his unit

charge and physician.

During the second interview, this time with the project supervisor, the patient was told of the demands that would be made of him with respect to work discipline. Unless the subject withdrew at this point, he was given a definite starting date and the unit physician arranged for transfer to the project unit.

After transfer to the project unit, the patient was seen by the social worker to begin to develop plans for leaving the hospital and for post-hospital living arrangements. Soon after selection for the project, the patient's parents or wife were seen to discuss with them the rehabilitation project, the role of the relative and her relationship to the client's over-all rehabilitation.

This intake process was followed for about a year. At that time the project team decided to try a somewhat simpler plan for selecting patients. This consisted of reviewing patients' records and eliminating those who clearly did not meet basic project criteria such as age or diagnosis. A short abstract was then prepared on those patients who seemed to be suitable. The abstract was then reviewed by the project counselor prior to his interview with the patient. If the patient appeared to be motivated for the project, he started immediately in the bakery for an "on-the-job" one-week trial period designed to evaluate the patient's functioning under actual working conditions and to give the patient an opportunity to determine if he really wanted the bakery project. This procedure, using an "on-the-job" trial, replaced the earlier method of evaluating readiness for the remainder of the project.

Referrals were easily obtained during the first half of the project. Generally, screening the population on one unit resulted in an adequate number of patients. Then a marked change was noticed. It was found that several units had to be screened and many patients interviewed to find one appropriate referral. This change probably resulted from a number of factors including the development during this period of additional programs

within the hospital designed to move patients in good or fair remission into the community as quickly as possible. Therefore, the schizophrenic population remaining in the hospital were long-term chronic patients who did not meet some of the original criteria for selection by this project. At this time, length of hospitalization as a measure of acceptability into the project was eliminated. It was also decided to work with patients who were considerably "sicker" than those accepted during the first 18 months. This naturally affected the "success" rate during the second half of the project. The time required to complete the bakery phase increased from seven or eight weeks to six months or longer for some of this chronic patient group. As a result of this change in hospital population the project accepted five or six "poor risks" for every "good risk". Because these later patients were poorer producers, a larger patient crew was needed in the bakery to meet production requirements. It is interesting to note that during this phase of the project, when it became known that we were working with both more acute and more chronic patients, a larger number of spontaneous referrals came from individual staff members on all professional and non-professional levels.

To insure their continued interest in and support of the project, personnel were kept informed of the progress of the patients they had referred. Every month a complete report was sent to each unit about the patients who had been referred. This report included not only those in the hospital and their status in the project but a follow up report on the patient in the community.

Psychological Tests

In our original project design we had expected to utilize certain psychological test instruments to estimate the level of functioning and to appraise attitudes toward work and supervision. With experience it became the feeling of the project staff that these psychological test measures contributed little meaningful information and that the entire project experience was in itself a testing situation which produced more adequate data on an individual's potential work adjustment in the community than any available psychological tests. Therefore, there

was no routine use of psychological tests, although the WAIS was used to identify patients with mental deficiency.

RELATIONSHIP WITH HOSPITAL DEPARTMENTS

Hospital Administration

The hospital administration had been cooperative with the concept of the project from the beginning of its development and continued its interest during the project's life. It must be recognized that the hospital is basically a treatment and custodial institution. Research, while respected and supported, is not its primary goal and research needs may sometimes have to give way to operational needs. Specifically, for example, unit personnel who had been oriented and trained in relation to the project had to be transferred to other units to meet administrative needs. Thus the project staff was constantly involved in training new unit personnel. This inevitably reduced the efficiency and progress of the project.

Industrial Therapy

The Industrial Therapy Department was involved with the project as far back as the first planning stages and relationships have continued to be close. Some changes in the usual I. T. functions were necessary to establish the project in the bakery. The I. T. department relinquished its responsibility for patient-workers in the bakery and turned it over to the project. They also willingly took responsibility for reassigning those patients in the bakery who were not to be included in the project.

Three of the original patient crew of 20 patients were eligible for the project. In addition, one older man who had worked in the bakery for some 14 years was allowed to remain in the bakery although not included in the project. Resistance to moving the remaining 16 patients to other work areas developed in only two cases. In one, a doctor had placed his former houseboy in the bakery and, although the doctor didn't want the patient back as a houseboy, he questioned giving the patient another work assignment. The Industrial Therapy Depart-

ment, however, backed the project personnel and the man was transferred. It served as a source of referrals for project workers and when the project was phasing out it re-assumed responsibility for staffing the bakery with patient-workers.

Rehabilitation Services

Complete cooperation was extended to the bakery project by the Department of Rehabilitation Services. The Supervisor of Rehabilitation Services visited the bakery and Handcraft and extended the cooperation of his department. When it became apparent that one of the major needs of the patients in the community was help in using leisure time, this department assigned an assistant supervisor to work with the project staff to explore recreational opportunities. One result was the publication of a brochure which was distributed to the patients listing free and low cost recreational facilities in Los Angeles.

At one point the project team felt that it would be desirable to have an additional work area to provide a number of work activities not available in the bakery. The I.T. department cooperated by making its woodshop available for this purpose. This facility was used for a period of six months as a supplementary work area to the bakery, for some 20 patients. While no valid conclusions can be drawn from the experience because of special circumstances surrounding its operation, lack of cooperation from Rehabilitation Services was certainly not the reason for terminating use of the woodshop.

Patients Accounts

Coordinating disbursal of the patient's funds when he leaves the hospital was an important factor in smoothing the patient's transition to the outside community. Several patients had on deposit fairly large sums of money received from disability payments. Often the hospital staff agreed that it would not be desirable for a particular patient to have a large sum of money on his person immediately upon leaving the hospital. Some means of handling this money had to be worked out between

Patients Accounts and the project counselor. In some cases this took the form of establishing an account in a Los Angeles bank with two signatures, that of the patient and that of a project staff member, required for making withdrawals. Another method of handling this money was to give the patient an amount which would cover his initial needs and then have him write the hospital for additional amounts as needed. When greater control was needed arrangements were made for the money at the hospital to be available only at the request of the social worker in the community. These procedures were generally successful although there were occasions in which these arrangements for adequate control were not followed.

This resulted in instances of patients having either more money than they could properly handle or cases in which inadequate sums were advanced for basic living needs. However, overall, the project's relationships with Patients Accounts proceeded smoothly.

Hospital Social Service and Psychology

The two departments are discussed together because certain similar problems were faced in developing relationships with both. In retrospect, it is recognized that the project did not sufficiently involve either department in the planning and preparatory stages of the project. This is in marked contrast to the active involvement of the Industrial Therapy Department. Because social workers and psychologists are professionals, we, perhaps, incorrectly assumed that involvement would result without deliberate conscious effort on the part of the project staff. This, too, is in contrast to the planned efforts toward involving the non-professional staff of the unit and of the bakery. We, perhaps, thought that professionals who already understand and support the project's rehabilitative goals would automatically identify themselves with the project activities.

Although each of the two department heads had agreed to contribute the half-time service of one of their staff members as part of the hospital's share of the project, we recognized that this required additional activity from departments which felt they were already overloaded. This,

too, is in contrast to the requirements from the Industrial Therapy Department which was called upon to relinquish one of its areas to the project rather than to provide additional services.

Any description of relationships involving individuals is necessarily more simply presented than are the actual relationships. In addition, the details of any particular set of relationships are too specific to be useful in total applicability to other situations, however superficially similar they may appear. Nevertheless, we want to extract elements from this set of relationships which may contribute to an understanding of some of the factors which may complicate and impede the development of smooth functioning between a demonstration project staff and existing institutional departments.

We feel that a demonstration project calls for flexibility on the part of the personnel working in it so that the changing needs of the project can be met. This, therefore, makes it undesirable to attempt to detail, in advance, the specific functions of each professional staff member on the project. In contrast, hospital department heads generally require a detailed listing of the specific duties and functions of any staff member. This difference resulted in delay in assigning a social worker to the project, because the project did not feel able or ready to specify in advance the total range of social service functions that the project required. The project wanted both the social worker and psychologist to become active members of the project team, who, together with the other members, would help delineate the functions of each team member.

A demonstration project by its very nature feels pressured to "prove" what it set out to demonstrate within a time limited period. Further, the relatively self-contained structure of a project makes possible and facilitates the development of less structured and less formal ways of getting the job done. Again, ongoing regular hospital departments may need a more highly structured apparatus for efficient functioning, in the larger role which they play within the institution. Here, too, these differences may cause conflict.

COUNSELING IN THE HOSPITAL

The introduction of a rehabilitation counselor into the hospital bakery was one of the principal methods used in changing this hospital industry into a work adjustment setting. Such an action by itself does not transform an industry into a rehabilitative environment, but the opportunity for increasing the emphasis upon the individual needs, problems and potentialities of the patients is enhanced.

The original intent was to have the counselor in the bakery assume a role similar to that of the counselor in Handcraft Industries. The counselor's function is to interpret reality and to help the patient develop ways of coping with the demands of the work environment. Appropriate work behavior is rewarded by pay raises and other measures which give recognition to growth and development. The emphasis of the counseling sessions is upon work and problems arising in the work situation.

Clients in the community workshop and patients in the hospital live in very different environments. The hospital as a "total institution" provides for all of the needs of the patient and makes very minimal demands on individual responsibility to maintain oneself in this environment, as eloquently described by Goffman (6). Living in the community, on the other hand, requires a continuous series of self-initiated decisions and activities. The qualities of the total institution affect even the patient work areas of the hospital. A technician wakes the patient, sees to it that he is properly dressed and gets to his breakfast, where he has no choice of menu, and other technicians are present to supervise his eating. If he has a work assignment, he may be escorted to his work station. In contrast, independent community living requires that the individual perform all of these functions and others on his own initiative.

Counseling in the hospital must be related to the realities of the hospital situation. One of its goals, however, is to help prepare the patient for work in the community workshop and for living in the demanding milieu of the community. The patient is encouraged to take the initiative to arise on his own, wash, dress and shave and get to the

work station on his own and on time. When this is accomplished, significant progress toward "work adjustment" has been made even before the patient arrives at work.

In the community workshop a good deal of the content of counseling is provided by discussion of work performance which is the basis for determining wages and pay raises. Patients in the bakery, as in all industries in this hospital, were not paid and therefore other rewards and motivations for performance were necessary. The promise of leaving the hospital was made the primary motivating factor for working in the bakery. A good deal of the content of counseling from the start concerned the process of setting tentative leave dates. Generally, in the early stages, the patient sought to influence the decision toward an early leave date, while the counselor focused on those work-related problems which indicated the need for a longer period of work adjustment training. Almost invariably, as the date of leaving became imminent, an interesting reversal of position took place. The patient experiencing anxiety in connection with leaving the total institution focused upon reasons why he was not ready to leave. The counselor, on the other hand, emphasized the patient's competence to cope with job demands, using the patient's bakery performance, with which they were both familiar, to support his position.

Individual counseling, focussing upon work-related problems, was the backbone of the counseling program. During the course of the project it was felt that a great deal of repetition occurred in the area of giving information concerning problems of living in the community, such as budgeting, shopping, food preparation, use of recreational facilities, finding and using public and private agencies serving the post-hospital patient. Group counseling was seen as a method of utilizing the counselor's time more effectively. The project population was divided into two groups, each meeting weekly with the counselor and occasionally with the project supervisor. These sessions were devoted primarily to information giving and exploring feelings concerning anticipated problems to be faced upon leaving the hospital as well as to work problems.

Because the values of "marathon" group counseling were being explored in the hospital while this project was in operation, it was decided to introduce it to the project. This involved a two-day, continuous counseling session, which ran seven hours per day, including the noon lunch which was shared by all members of the group. The goal was to have the "marathon" group members spend a significant amount of time together, interacting, sharing experiences and learning to know each other. The early patients had experienced anomie when they moved into the community and despite the fact that many were living in the same small hotel, they did not relate to each other. It was thought the marathon group experience might help to overcome the feelings of isolation. Individual group and "marathon" group counseling were all utilized as a regular part of the counseling procedure.

Contact was maintained with the patient after he left the hospital through weekly group sessions held in the small hotel in which several project clients lived. All patients who had recently left the hospital, those working in Handcraft, and any who were unemployed, were expected to attend. Any other project participants were welcome to come but were not urged. The attendance ranged from as few as six to as many as eighteen. This group concentrated on various topics, many of which were brought up by the clients. Among the problems which were frequently discussed were budgeting money, what to tell an employer about hospitalization, how to handle a job interview, resources for finding jobs, and use of leisure time.

OTHER RELATIONSHIPS

The relationship between patient and counselor was only one relationship which the patient had to make. He also had to relate to the baker for whom he was working, to the bakery foreman, as well as the project supervisor. Essentially he related to the baker and the foreman in the way in which employees generally relate to foremen. With normally functioning people, this is usually a comparitively simple matter. However, with patients who have a poor vocational history and poor work habits, production demands create problems and some mechanism for handling these problems was necessary. The project counselor ful-

filled this function and was available to discuss with the patient his problems in relationship and to help him develop ways of handling these problems. The supervisor served as the "boss" making demands for performance and appropriate behavior, and supporting the production demands made by the baker. The supervisor had the ultimate authority to suspend or drop patients from the project.

However, these roles and functions did not always remain clearly separated. The bakers did not always accept the patients as workers and excused poor performance because they were "only patients". While the counselor should have been concerned only with helping patients solving work related problems, there were some occasions when he was in the position of having to make demands for production when the supervisor's other duties took him out of the bakery.

Originally, it was assumed that the project counselor would spend his time in the bakery production area or in an office in the same location. Typically, patients must go to an office in the administrative area at a considerable distance from where they live and work to see a professional person. The project felt that it would be desirable for the counselor not to be separated from the work area. It was thought to be important for him to be intimately a part of the work situation and to be immediately available for counseling when critical incidents arose. However, it soon became apparent that the counselor did not want to be separated from his professional colleagues in the professional offices. He did not want, nor did the project director feel that he should, spend <u>all</u> of his time in the company of patients and non-professionals.

Relationships with Families

Routinely, relatives of new admissions to the hospital are contacted by the Social Service Dept. to obtain data for the social history. There is no routine professional contact with relatives again until leave plans are being considered, unless problems arise requiring the involvement of relatives for their solution.

In this project relatives significant in the patient's life were involved from the time of the patient's entry into the program. The first step was an interview at the hospital with the relative on a day convenient for him. Since most of these interviews had to be held at times when relatives were not working, project staff had to be available at times other than normal work time, like Saturdays. One of the purposes of the interview was to acquaint the family with the project goals, procedures and services. The major goal of this and other contact with relatives was to establish a relationship which could be utilized for the best interest of the patient while he was in the hospital and later in the community.

In almost every instance, the physician and project staff agreed on the recommendation that the patient not return to the home of his parents or wife. In general, because it was felt that the home had a negative influence on the patient. The relationship which had been developed made it possible for the project staff to obtain acceptance for this "hands-off" recommendation. There was little resistance to this request in most instances. This relationship, coupled with the possibility that relatives may have actually been relieved to have professional approval for limiting contacts with their family members may explain this rather ready acceptance. Some relatives were encouraged to maintain limited contact and offer occasional assistance, e.g., an invitation for a dinner or an outing or providing funds for special needs.

III COMMUNITY PHASE

HANDCRAFT INDUSTRIES

The community phase of the project was centered around Handcraft Industries, a division of the Jewish Vocational Service of Los Angeles, located in Hollywood, some 60 miles from the State Hospital. Since 1954, Handcraft has operated as a community agency providing work adjustment services for various handicapped persons, and since 1957 has been emphasizing service to the mentally ill and mentally retarded. The placement service of the Jewish Vocational Service also served project clients. The J.V.S. is a constituent agency of the Jewish Federation Council of Los Angeles and due to this relationship a very helpful additional support was obtained in the form of interest-free loans from another constituent agency, the Jewish Free Loan Association.

Ordinarily Handcraft, like other community agencies, selects those clients who, it feels, can best utilize its services from referrals received. As a part of this joint project with Camarillo State Hospital, Handcraft gave up this freedom to choose its clients. This was done because of the recognition that the project staff at the hospital had to feel assured that project patients would be accepted by Handcraft without the uncertainties of a separate intake process. Conversely, the Handcraft staff had to feel that those who would be sent to them by this project would be the kind of client the workshop staff would have accepted through its own intake process. Therefore, one intake process was developed for the total project and all patients who completed the bakery phase were accepted at Handcraft. Thus, it was possible to present the bakery-Handcraft program as a "package deal" at the time of screening for the project and to assure the patient that when he completed the bakery phase he would be moved to the community and have a place at Handcraft. A more detailed description of this joint operation is given in an earlier paper. (7)

To facilitate a smooth transition from bakery to workshop, patients, while still working in the bakery, were given a detailed description of the Handcraft facil-

ities and program and then were taken in small groups to visit. There they were given further orientation to Handcraft by its professional staff. They also had a chance to see and talk with some of their former co-workers from the bakery. Questions and reactions from the visit provided content for subsequent counseling sessions in the hospital. The project staff were convinced of the necessity of giving the patient the experience of seeing for himself the work setting he would enter. No amount of talking about and describing the next step can substitute for an actual visit to make this real for the long term institutionalized patient. Early in the patient's time in the bakery, a report was sent to Handcraft including information on pre and in-hospital history, emphasizing vocational problems and achievements prior to his involvement in the project. Shortly before moving to Handcraft a second report was prepared which included the psychiatric summary, copies of any psychological tests, and a detailed appraisal of performance in the bakery. The initial contact with the client provided the workshop counselor an opportunity to discuss feelings and motivations regarding entrance into the workshop.

Handcraft was a well established transitional work adjustment setting at the time this project was developed. It was utilized by the project 1) to serve as a general model for the modification of the bakery toward becoming a work adjustment setting and 2) to provide the second phase of the work adjustment experience for project patients. Handcraft follows, generally, the description of a work adjustment center given by Gellman (8) and is described in some detail in a paper by its director (9).

In brief, Handcraft's physical appearance closely resembles a factory in terms of the plant layout, use of office space and production practices. It contracts work from industry. There is a production staff and a professional staff. The workshop is capable of serving as many as 45 clients while maintaining a close relationship between client and staff. Following the initial starting rate of $.50 an hour, the client's wages are based upon productivity which is reviewed and evaluated no less than twice a month at which time hourly rates are set ranging

up to $1.30 per hour.

The director is a psychologist with an industrial background. Before the project began the workshop employed one full-time vocational rehabilitation counselor and one shop foreman and assistant foreman. Through the project a second counselor and a foreman were added to the staff and additional services of a part-time contract salesman were obtained.

The counselor's function is to exploit every facet of the work setting in order to help the client learn to cope with the demands of industry. Individual and group counseling centers around work and work related problems and is used to build positive work habits. Critical incident counseling as well as regularly scheduled individual counseling sessions are provided.

The work experience at Handcraft simulates the work environment of competitive industry. Clients punch a time clock, individual production records are maintained and clients are expected to conform to the workshop's regulations which are modeled after those of industry. Emphasis is upon work adjustment at a level more demanding than that of the bakery, rather than on skill training. The work involves assembly or packaging. Many machines are used, particularly those in the blister and shrink packaging area. These require some training in addition to judgement, dexterity and responsibility.

Handcraft clients who demonstrate their readiness for regular employment are referred to the placement section of the Jewish Vocational Service and to the California State Employment Service for job placement help.

JEWISH FREE LOAN

Most project clients needed financial support in the period from leaving the hospital until their Handcraft earnings were sufficient to meet their living expenses. This need was well met by the cooperation of the Jewish Free Loan Association which made interest free loans available to project clients. The board of directors of the Jewish Vocational Service guaranteed these loans.

Initially, loans of variable amounts were granted. However, it was determined that about $150 was required to meet the transitional financial needs of most clients and this then became a standard loan. The loans were deposited in a special bank account of the J.V.S. and disbursement of the funds to the clients was supervised by the client's workshop counselor. Forty-seven loans, totaling $5,790 were granted. At the time of writing, 27 loans were paid in full and all of the remaining 20 loans were repaid partially. $1,757.72 still remained unpaid but it is anticipated that a substantial portion will be repaid.

Individuals with the very poor work histories of our subjects, with their hospitalization record and lack of material assets, are generally unable to get loans from any lending agency, because they are seen as extremely poor loan risks. Yet, within the structure of this project, they seem to show a reasonably good record of repayment.

It may be of interest to speculate on some of the reasons why this favorable record of repayment was achieved. The loan was seen as a part of project services and repayment as part of the client's commitment to the total project. The repayment record may also be a response to the confidence implied by granting of the loan. Certainly involved in the repayment record was the fact that the payment obligation was included as part of the content of counseling.

The involvement of the Jewish Free Loan Association made it possible for patients to leave the hospital earlier than would otherwise have been possible. The simple application procedure developed by the J.F.L.A. made the service useable by this group of clients. The knowledge that such financial aid is available should be an aid to the clients in coping with future periods of financial stress. In addition, services such as J.V.S. and J.F.L.A. may contribute to the use of the services of various community resources when needed.

POST HOSPITAL RESIDENCE

In our original thinking the assumption was made that patients would return to their pre-hospital residence,

"within easy commutation distance to Handcraft Industries in Hollywood". Beginning with the first client, however, the unit physician strongly recommended, and the project and unit staff concurred, that patients not return to their parental or conjugal homes. This resulted in project personnel becoming involved in making arrangements for living accommodations for project patients who were ready to leave the hospital.

Three types of living arrangements were utilized. Family care homes, supervised by the State Bureau of Social Work were used to the extent that they were available for those patients for whom continued supervision in a family-like atmosphere was desirable. The two other types of living arrangements began to be utilized after loan funds became available. One was "The Portals" house for men, a community supported halfway house with a capacity of only ten or twelve persons, and the other, the Cinema Hotel, a small commercial hotel, located one block from Handcraft Industries. The residence of choice was determined by an evaluation of the needs of the patient but this was frequently altered by the availability of living facilities at the time the patient was ready to leave the hospital. Some patients, judged to be in need of a family-care setting, had to be placed in the commercial hotel because a suitable family-care home was not available at the time of maximum readiness to enter the community. The alternative would have been continued confinement in the State Hospital after they had completed the work adjustment program in the bakery. Further, even though Portals extended its fullest cooperation to the project, its facilities were not always available when needed. An additional limitation on the use of Portals was its requirement that residents must have had an experience in independent living. Many of the project clients did not meet this requirement.

SOCIAL SERVICES IN THE COMMUNITY

Schizophrenic patients who have had lengthy hospitalization generally require a number of kinds of support if they are going to remain out of the hospital. Our experience has been that unless there is a professional person working directly with these patients, they will

probably be unable to use effectively community resources to remain in the community.

The Bureau of Social Work was the unit within the Department of Mental Hygiene which carried responsibility for patients in the community on convalescent leave including those in family care. Almost all of the project patients were placed on convalescent status on leaving the hospital in order to be certain that the services of the Bureau would be available to them.

In the planning of the project, as mentioned earlier, we anticipated that project patients would return to their pre-hospital homes and that, therefore, family members would assist the patient in making their adjustment to living in the community. This would include help in obtaining medical and psychiatric care, and in meeting recreational and social needs. Therefore, we did not feel that the project would become involved in arrangements for meeting these "non-work" needs. In actuality, return to the pre-hospital homes was contra-indicated for almost all of the project patients. In retrospect, therefore, it was unfortunate that the project planning did not include the Bureau of Social Work.

Therefore, we found ourselves requesting services from the Bureau at the time of immediate need without having given the Bureau an adequate opportunity to plan its involvement with project patients.

Relationships between the Bureau staff and project staff varied with the phase of the project. In the early months of the project, contacts were established with Bureau staff members. Relatively few patients were completing the hospital phase, therefore, requests for service from the Bureau were limited. Service for this group was good and relationships between the two staffs similarly were good. As the project continued and larger numbers of patients were being moved out of the Hospital, the need for social services from the Bureau progressively increased. It was during this middle period that the project staff felt that needed services were not available promptly enough. However, quite possibly, had the Bureau been involved earlier, many of the dissatisfactions of

the project staff would have been obviated.

The problems, with respect to the availability of needed community social services, fell largely into the following areas:

1) Delay in getting family care homes
2) Delay in initial appointment following return to the community
3) Intervals between interviews with the patient were too long
4) Lack of adequate arrangements for the continuity of medication.

The delays in obtaining family care homes should not be ascribed to deficiencies in the functioning of the Bureau of Social Work. It should be recognized that there has never been a sufficient number of adequate family care homes because of the failure of the community to provide such homes in sufficient numbers. Beyond this, most of the homes which became available were not located in areas within reasonable commutation distance of Handcraft Industries.

The delay in securing the initial appointment after the patient returned to the community may have resulted from delays in forwarding patient records to the Bureau.

The length of time between interviews with patients may have been primarily due to the large case loads carried by the Bureau staff.

The problem of the lack of continuity in providing medication in the period following release from the hospital is a long standing one and is only one of the problems resulting from the discontinuity in service to and responsibility for the mental patient re-entering the community. In the hospital the taking of medication is closely supervised by nursing personnel. However, when the patient re-enters the community there is no such close and direct supervision in regard to medication. This problem is discussed in some detail in a paper by Vargas and Goertzel (10).

In the later phase of the project, the problem areas discussed above were virtually eliminated for project patients who lived in the area served by the West Side office of the Bureau of Social Work. This included most of the project members. The designation of one well qualified, motivated staff member to serve the project group resulted in excellent social services being provided.

In an earlier section we referred to the value of housing all of the project patients in the Hospital on one unit. Our experience in the post-hospital phase, strongly suggests that it is similarly valuable to avoid the fragmentation of the project case load among a number of workers. If this is done, project clients do not constitute a major portion of the case load of any worker. The workers are then less able to become intimately involved with the project.

LEISURE TIME ACTIVITIES

Post-hospital schizophrenic patients, like other members of the community, have a variety of needs. This includes a place to live, a job, medical care and satisfying leisure time activity. Our experience has been that these patients need help in using the facilities which exist to meet these needs. While this project was primarily oriented to meeting work needs, we could not ignore these other needs. Many project patients were able to function on the job but experienced difficulty in occupying their evenings and weekends. We found that a substantial portion of the group counseling sessions were devoted to helping the members use their leisure time in a more satisfying way.

In the hospital, the Rehabilitation Department devotes itself to planning and conducting leisure time activities for the patients. Its interest did not end when the patient left the hospital. The project staff and Rehabilitation Department personnel worked together to locate appropriate recreational resources and to find ways of assisting patients to utilize these facilities. One concrete product of this cooperative effort is a "Directory of Leisure Time Activities" emphasizing

those which are free or minimal in cost. It presents fifty-two different resources, each located on a map, with a brief description of what each offers and the cost.

IV PRESENTATION OF FINDINGS

There is no single, agreed-upon criterion of success in the rehabilitation of mental hospital patients. Getting out of the hospital is one widely used measure. Some people regard getting out of the hospital as not a fully adequate measure: they maintain that only remaining out of the hospital for a significantly long period of time can be regarded as a successful outcome. Others insist that a person is not rehabilitated unless he functions as an independent and productive citizen. We believe that each of these three levels may be meaningful for a particular individual. For a long-time patient, to break the years of continuous hospitalization with an interval in the outside world may be a more difficult achievement than for a short term patient to return to regular employment. Perhaps what is needed is the creation of a series of criteria based upon a developmental sequence.

For this project, three levels of evaluating success have been designated: Level I--separation from the hospital, or simply "getting out"; Level II--remaining in the community continuously for six months or longer, or simply "staying out"; Level III--self-support during the six months of community tenure or simply "self-support."

The findings are based exclusively on the experiences of the subjects on their first separation from the hospital while on the project. Not included in the findings are the experiences resulting from a "turn around" procedure in which project staff continued to work with a number of the project patients who were returned to the hospital after a period in the community with the goal of giving them another opportunity for community living.

These three levels, in a sense, parallel the normal developmental sequence beginning in adolescence. Typically, the adolescent first has experience in "getting out" of the parental home and returning after a period following an interval at college or at a seasonal job away from home. He may then move on to a more extended experience in living away from home while still not self-supporting.

Ultimately, of course, he becomes self-supporting.

The original intention was to use one continuous year in the community as a major criterion of success. However, a large number of patients who entered the community during the latter stages of the project would be excluded as they would not have had an opportunity to complete a full year in the community at the cutoff time for collecting data for this report, May 31, 1966.

Six months appeared to be a reasonable and practical length of time to use as a criterion for "staying out" of the hospital. The typical project patient who gets out of the hospital spends one and a half months at Handcraft. Thus he would have four and a half months in the community without the support of employment provided by the project. Six months is the longest period possible that would not eliminate an appreciable portion of the population. Only four subjects are excluded when this time period is used. If one year had been used, 25 subjects would have been excluded.

A total of 146 patients were served by the project. Of this number, 89 left the hospital resulting in a success rate of 61% at Level I. However, as stated, four of the 89 patients did not have an opportunity to be in the community for six months by the cutoff date for data collection. For clarity in presentation, these four subjects are excluded from all subsequent data analysis.

TABLE I.

LEVELS OF SUCCESS

Entered Project	Level I (Left Hospital)	Level II (Stayed out 6 mo.)	Level III (Self-Supporting)
142	85 (60%)	63 (74%)	31 (49%)
	(Remained in Hospital) 57	(Returned to Hospital) 22	(Not Self-Supporting) 32

From Table I, we find that within the project, six out of 10 patients left the hospital and, of those who got out, three out of four stayed out six months or longer. Those who stayed out are divided equally into those who were essentially self-supporting and those who were substantially not self-supporting.

In evaluating the effectiveness of the project with respect to criteria other than simply getting out of the hospital, we find that forty-four per cent of those who entered the project left the hospital and stayed out six months or longer and twenty-two per cent of all who entered the project went on to achieve self-support.

As this was not a controlled study, we cannot draw any clear conclusions as to the effectiveness, if any, of the work program, the individual and group counseling, and of the community supports offered by the project. There were no comparable groups for which follow-up data could be obtained. Also, within the project population, there were no initially comparable sub-groups who received different predetermined portions of our rehabilitative services. Nevertheless, something can be learned from examining the data concerning the project population and from our clinical observations.

Data is presented on the following variables and are related to the three levels of success: age, education, work history, independent living, hospitalization, time in bakery, time in Handcraft and first post-hospital residence. These variables were selected on the basis of our clinical observations during the life of the project as variables which might be related to success.

Data was gathered on a number of other variables which are not reported for various reasons including: lack of confidence in the reliability of the data, data not available for significant numbers of subjects, very few instances of the event or it is an almost universal characteristic of the population. These include pre-project data on diagnosis, marital status, anti-social behavior, criminal records, average time in community on previous hospital releases; and project data such as various ratings in the bakery and in Handcraft, use of

medication, time to secure job, number of jobs held, average length of employment, method of securing employment, intelligence and performance tests, etc.

AGE

All subjects were within the range of 18 to 45 years of age at the time of admission to the study in accordance with the project design. For the purpose of analysis, the population was divided into three age groups which were as equal as possible using whole years as cutoff points. The young group is from 18 through 22 years; middle group is from 23 through 30 years; the older group is from 31 through 45 years of age.

TABLE II

AGE AND SUCCESS LEVEL

	Total	Level I	Level II	Level III	
Young	43	23 (53%)	16 (70%)	10 (63%)	Success
		20	7	6	Failure
Middle	51	36 (71%)	27 (75%)	10 (37%)	Success
		15	9	17	Failure
Older	48	26 (54%)	20 (77%)	11 (55%)	Success
		22	6	9	Failure

Table II shows that more than half of the subjects left the hospital regardless of age group. A much larger proportion, however, of the middle group did get out. Having gotten out of the hospital, age group was not related to staying out. While a larger proportion of the middle group got out of the hospital, the results are reverse so far as becoming self-supporting. The result of more middle range patients getting out and fewer of those who stay out achieving self-support is that there is no direct relationship between age grouping in the

original population served in the hospital and self-support in the community. The percentages of the age groupings in the project ultimately achieving self-support are: Young 23%, Middle 20%, and Older 23%. To put this finding in another way, age is related to success on Levels I and II but not to success on Level III. However, a much larger proportion of the 23 to 30 year group get out of the hospital and a similar proportion stay out. Looking at the self-supporting subjects in the community, we see that each age group contributes essentially the same number; however, there are only six in the young and nine in the older group who are in the community and not self-supporting, compared with 17 in the middle group who are not self-supporting.

The large proportion of the middle range leaving the hospital may be understood, perhaps, if we accept the concept that the criterion for leaving the hospital was essentially that, in the judgement of the staff, the patient had a reasonable chance of being able to remain in the community for a significant length of time. On this criterion, staff judgement seems to have been correct. The proportion of the middle group who remained in the community six months or longer is the same as the proportion of the smaller numbers in the other two age groupings who remained in the community. If the number in the middle group who were helped to leave the hospital had been kept down to the number in the other age groups, it follows that a substantial number of patients who could have remained out of the hospital would have been denied this opportunity. It should be remembered that the 17 men who are categorized as Level III "failures" are also included among the Level II "successes". It bears repeating that there is no single agreed on criterion of success in the rehabilitation of the chronic schizophrenic patient. We agree with Vitale and McDonough (11) that, "It appears to be unrealistic and unfair to expect these men to continue to progress to greater improvement and finally to reach some degree of self support." We are unable to offer an adequate explanation of why a much larger proportion of the 23 to 30 year group was able to remain in the community but not achieve self support, than was true for the other two age groupings.

EDUCATION

Educational level was not included as a criterion for selection in this study as we know of no evidence of a significant relationship between education and prognosis in the rehabilitation of hospitalized schizophrenic patients. The range in educational level in the sample is very large, from two years of grammar school to one year of graduate study. The bulk of the population falls in the group having "some high school". The percentage distribution of the three categories selected are: less than high school, 28%; some high school or high school graduation, 51%; more than high school, 20%.

TABLE III

EDUCATION AND SUCCESS LEVEL

	Total	Level I	Level II	Level III
Less than High School	40	26 (65%)	20 (77%)	6 (30%)
		14	6	14
High School	72	39 (54%)	25 (64%)	17 (68%)
		33	14	8
More than High School	29	20 (69%)	18 (90%)	8 (44%)
		9	2	10

As expected, there are no consistent findings of any relationship between education and success in this project. Although there is no clear relationship between education and getting out of the hospital, those whose schooling extends beyond high school generally appear to have a better chance of staying out once they get out. Subjects with less than high school education are less likely to obtain employment while in the community. This finding may not be related to their psychiatric problems but may be related to problems faced generally by job-seekers with

minimal schooling. The net result in respect to Level III is that only 15% of the total project group having less than high school education achieved self-support, compared with 24% of the high school and 28% of the college groups.

WORK EXPERIENCE

It should be borne in mind that the entire population selected for this project was made up of men who had a poor history of pre-hospital work adjustment. Only 33% had worked for as much as six months or longer at any time in their lives.

TABLE IV

PRE-HOSPITAL WORK HISTORY AND SUCCESS LEVEL

	Total	Level I	Level II	Level III
Yes	47	31 (66%)	22 (71%)	14 (64%)
		16	9	8
No	95	54 (57%)	41 (76%)	17 (42%)
		41	13	24

Table IV shows that only 47 patients or 33% of the total sample had worked for six months or longer. It was anticipated that those patients who had worked for six months or longer at some time in the past would more likely be able to work again in the future than would those who had not worked in the past. Our expectations were supported. Thirty per cent of the total project sample with such previous work experience achieved self-support on the project, while only 18% of the no-work experience group did so. There is only a slight positive relationship between work experience and <u>getting out</u> of the hospital and practically no relationship between work experience and <u>staying out</u> after getting out. The strongest relationship is between work experience and self-support for those who did get out and stayed out. However, the success level with those who had no previous

work experience was high enough to include this group in vocational rehabilitation efforts.

INDEPENDENT LIVING PRIOR TO HOSPITALIZATION

This variable was included in our analysis because early in the project we recognized that many patients would need to live independently in Portals House or the Cinema Hotel. Only one-third of the population were living away from their parental home at the time of hospitalization. Our figures suggest that living away from the family at the time of hospitalization is not related to Levels I or II and is perhaps slightly positively related to Level III, namely, self-support.

TABLE V

PRE-HOSPITAL INDEPENDENT LIVING AND SUCCESS LEVEL

	Total	Level I	Level II	Level III
Yes	47	27 (57%)	21 (78%)	12 (57%)
		20	6	9
No	95	58 (61%)	42 (72%)	19 (45%)
		37	16	23

DURATION OF HOSPITALIZATION

One of the original criteria for selection for the project was a hospitalization of three to 24 months. After one year of experience in the project, during which time considerable success was achieved in getting patients out of the hospital, the project staff was eager to serve patients hospitalized longer than two years. Further, length of a particular hospitalization is often an artifact of the discharge practices of the unit physician. We found patients who, although hospitalized less than three months under the current commitment, had, in fact, long hospitalizations under several commitments and clearly were in need of project services. We,

therefore, removed length of current hospitalization as a limitation on selection.

Total time hospitalized prior to admission to the project was chosen as the best single measure of chronicity. Number of hospitalizations was not used for the reasons indicated. The total population was divided into three approximately equal groups with respect to total months hospitalized; short hospitalization (less than 13 months), 32%; medium hospitalization (13 through 36 months), 35%; and long hospitalization (37 months or longer), 34%. The range for length of hospitalization is from two to almost 200 months.

TABLE VI

LENGTH OF HOSPITALIZATION AND SUCCESS LEVEL

	Total	Level I	Level II	Level III
Short	45	26 (58%)	21 (81%)	13 (62%)
		19	5	8
Medium	49	34 (69%)	23 (68%)	11 (48%)
		15	11	12
Long	48	25 (52%)	19 (76%)	7 (37%)
		23	6	12

If duration of hospitalization were inversely related to success, one would expect consistent declines in success rates so that short hospitalization would have the highest success rate at all three levels, long hospitalization would have the lowest success rate, and medium hospitalization would occupy an intermediate position. Although this is clearly not the case, it does hold with respect to the proportion of subjects remaining out of the hospital who achieve self-support. With regard to the total project population, we found 29% of the medium hospitalization group achieved this level and only 15%

of the long hospitalization group did so. There is no consistent trend or major differences in getting out or staying out of the hospital in relationship to length of hospitalization.

TIME IN BAKERY

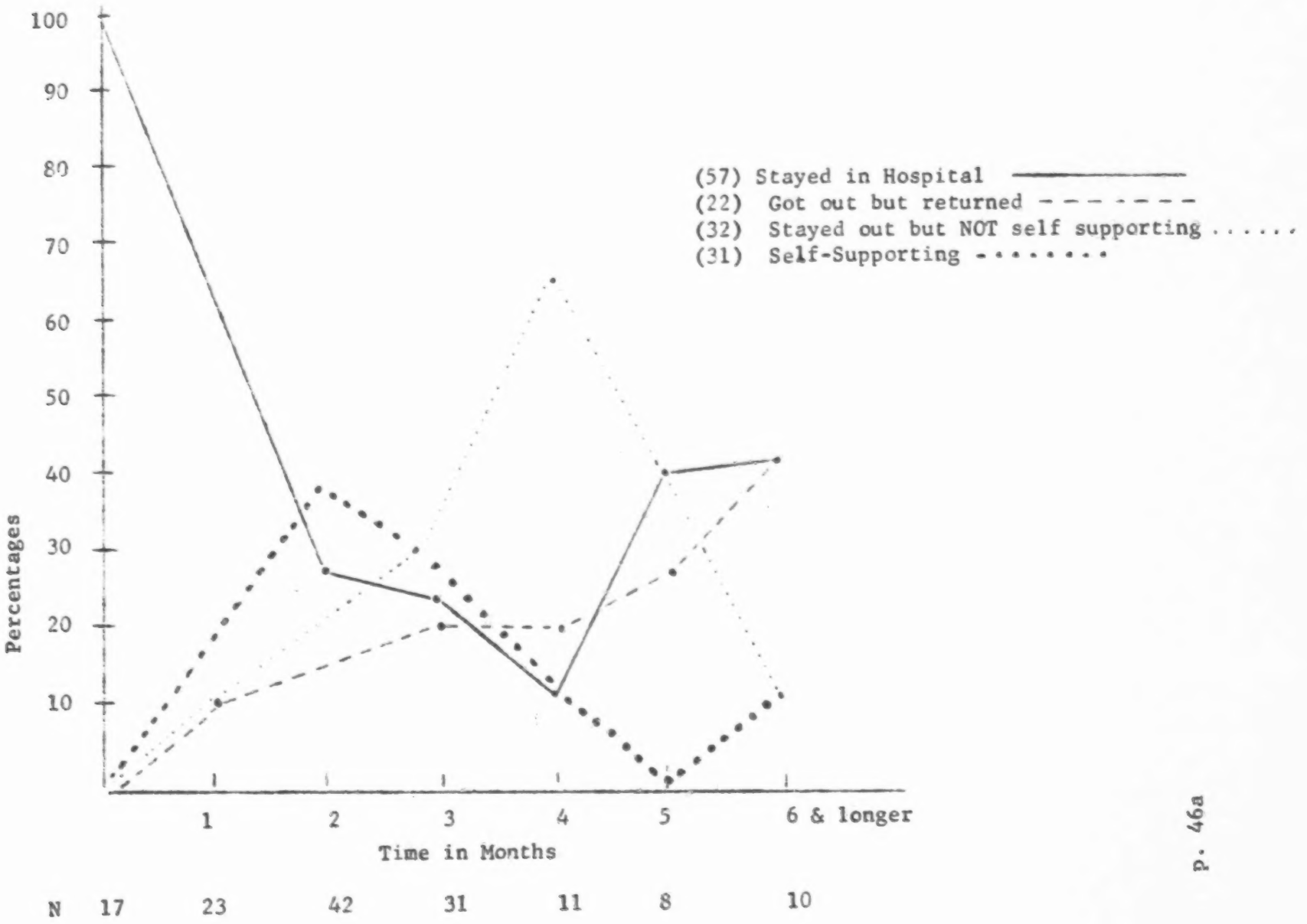
Until this point, descriptive and historic data prior to admission to the project has been presented. "Time in Bakery" is the first measure obtained from within the operation of the study. It is an important enough measure to examine in some detail. Time in the bakery is presented in terms of months or fractions of months rather than in only three classes, such as short, medium and long. Success is presented in terms of percentages of patients in each monthly "time in bakery group" who reached their highest level of success.

The original design estimated that on the average subjects would spend six months in the bakery and six months in Handcraft. Actually, only ten of the 142 subjects in the study were in the bakery six months or longer. The median time in the bakery was 2.7 months and the modal month was two. The range was quite large, from seven to 359 days.

From Figure I, it can be seen that time in the bakery is related to each of the levels of success but it is not a simple relationship. The clearest difference is for the less-than-one-month in the bakery group. None left the hospital through the project. For the group of 23 patients in the bakery one month but less than two, approximately sixty per cent did not leave the hospital, ten per cent got out but returned, ten per cent stayed out but didn't work and twenty per cent stayed out and were self-supporting. The two and the three-months groups have the largest number of subjects. Working in the bakery 2 or 3 months is not predictive of "Level of Success". Roughly, one-fourth of those who did not get out of the hospital and one-fourth of each of the three levels of "Success" groups spent either 2 or 3 months in the bakery.

FIGURE I

TIME IN BAKERY AND SUCCESS LEVEL



The small numbers who spent four or more months in the bakery permit little confidence in any observations made concerning these groups. With this caution, we observe that the four-month in the bakery group is made up primarily of patients who got out and stayed out of the hospital but were not self-supporting. Seven of the 11 subjects are in this category. None of the five-month and only one of the 10 in the six-month group reached the level of self-support.

Looking at Figure I, we see that those who did not leave the hospital spend either a very short or a long time in the bakery. The curve for the group who got out of the hospital but returned within six months increases with each successive "month in bakery" sample in an almost linear relationship. While the second level of success group consists of increasing proportions of the subjects in the bakery from zero to four months and then drops dramatically with longer time in the bakery. The same kind of relationship is true for the self-supporting group, except that this peak is at two months rather than four.

Overall, it appears that short time in the bakery is related to failure or the highest level of success while the longer periods of time in the bakery are associated with failure and with the lower levels of success. Those, who, the staff were convinced, could not function in the bakery even with the support offered, were dropped or withdrew very early; many in less than one month. Those who eventually became self-supporting tended to remain in the bakery a shorter time than those who left the hospital but did not become self-supporting. This is probably explained by the fact that, in the judgement of the staff, they were ready to function in the community earlier than those who subsequently returned to the hospital or remained in the community but required financial assistance.

TIME IN HANDCRAFT

Of the 142 patients served in the bakery, 85 completed this first phase and left the hospital. Seventy-two of the latter group entered Handcraft.

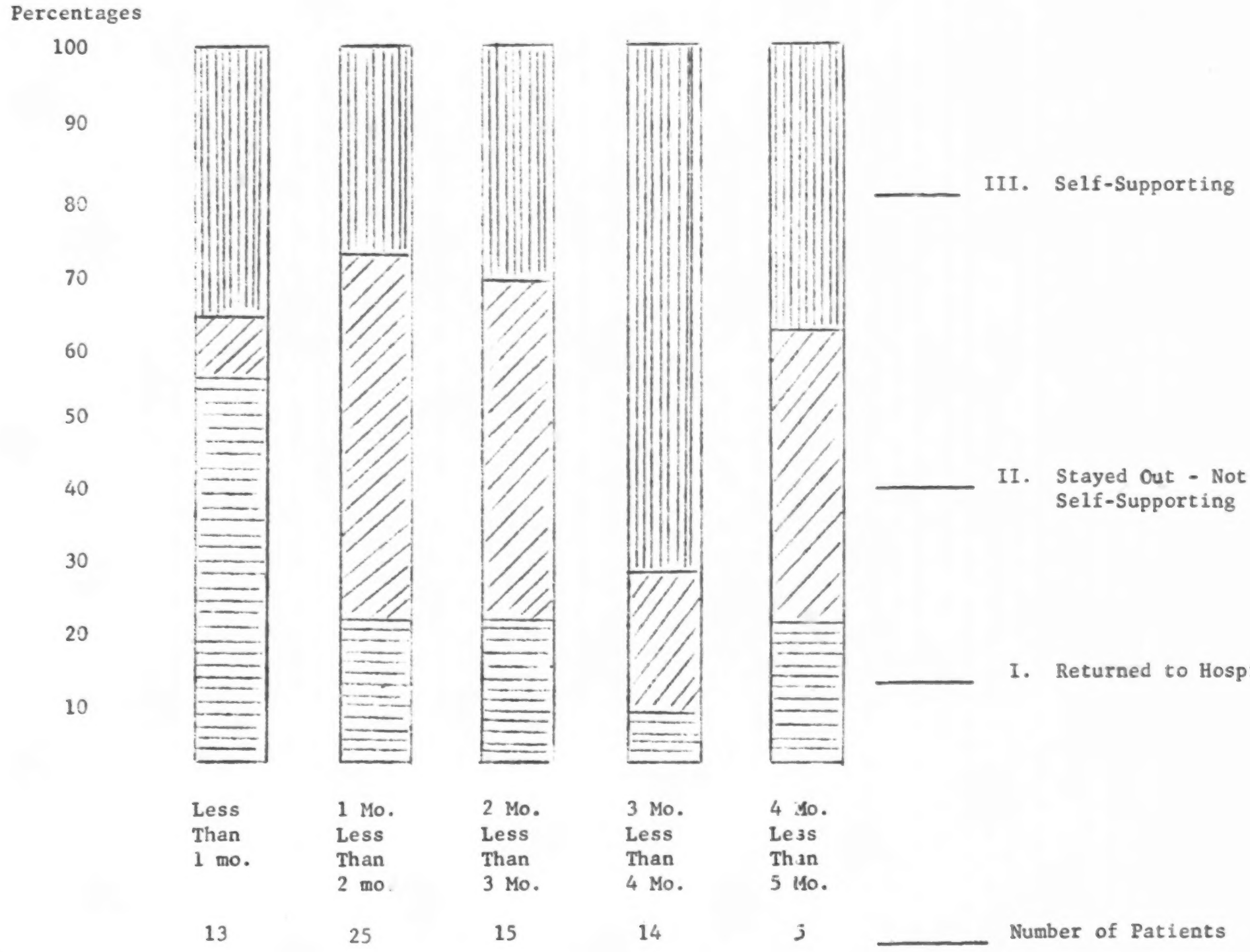
It was originally expected that project patients would spend an average of six months in the bakery and six months in Handcraft. We have already reported that the typical patient in actuality spent 2½ months in the bakery. The modal time in Handcraft proved to be one month and the median time is less than two months. The range of time for the workshop was from one day to 138 days. The vast majority of the clients left the workshop before the end of the third month. The number who spend four months at Handcraft is so small that significant observations and interpretations must be restricted to the first three months.

The data presented in Figure II suggests that time in Handcraft is related to each level of success. The figure shows that a large proportion of clients remaining in Handcraft for less than one month returned to the hospital while an extremely large proportion who remained in Handcraft the longest, that is between three and four months, remained in the community and became self-supporting. These results show that the majority of clients who left or were dropped from the workshop program in less than one month were unlikely to remain in the community and to be self-supporting. If clients spent only one or two months in Handcraft, they were unlikely to become self-supporting. Clients who received three or four months of work adjustment experience were much more likely to be employed after leaving the workshop.

It is possible that some clients could have reached Level III following their experience in the bakery without a transitional work adjustment experience in the community. This had been observed with some clients who did not enter the workshop, and with others who left the workshop after only a few days and secured their own employment. It is very probable that the reason a relatively high proportion of Level III successes stayed in the workshop less than a month is that these clients did not need a longer transitional work experience.

The Handcraft experience does appear to prepare psychiatric hospital patients to adjust to the community and to employment. Clients with the greatest vocational potential received a longer work adjustment experience than others with a lesser potential for self-support.

FIGURE II. Time in Handcraft and Success Level



(However, involved with the extensiveness of the experience were factors such as motivation which entered into this relationship.)

Overall, clients who seemed to have potential to become self-supporting citizens in the community were retained at Handcraft longer than those who did not show such potential. The longer time that those with poorer potential were worked with in the bakery can be understood by recognizing that the goal of the project staff in the hospital was primarily to get patients out of the hospital and into community living, while the goal of Handcraft was to help clients to become self-supporting.

THOSE WHO DID NOT ENTER HANDCRAFT

One of the goals of this project was to increase the proportion of referrals from a large state hospital who utilize a specific community's resources. A close relationship between the hospital and a community workshop was developed to increase the effectiveness of a referral system between the organizations. An approach of presenting both the hospital industry and the workshop as a "package deal" was successfully utilized.

Although a great majority of the referrals entered the workshop, the bakery graduates who did not utilize this community service should be examined. There were 85 graduates of whom 72 (85%) did enter Handcraft. Table VII presents a summary of the 13 who did not enter Handcraft and shows their success level.

Of those who did not enter Handcraft, one-half rejected its program, while the remainder were either returned to the hospital before they could enter the workshop or they were not referred.

The project was generally successful in getting patients to accept referral to the community workshop. Of the 13 who did not enter the workshop, there were three who can be considered as having accepted referral but were returned to the hospital within the first week or so before having an opportunity to enter the workshop.

TABLE VII

SUBJECTS WHO DID NOT ENTER HANDCRAFT

	Highest Success Level Attained		
	I	II	III
1. Rejected Handcraft			
In Hospital (1)		1	
In Community (6)	1	3	2
2. Accepted Handcraft but Rehospitalized			
Before Handcraft interview (1)	1		
While on Handcraft waiting list (2)	2		
3. No referral to Handcraft			
Patient left Hospital without any coordination with project (2)	1	1	
Staff questioned need (1)		1	
TOTAL (13)	5	6	2

The seven referrals who rejected Handcraft did so because they felt they did not need Handcraft, or wanted to find their own jobs, or wanted to disassociate themselves from any attachment to the hospital. Two of these seven achieved self-support. In the cases where no referrals were made, one patient was released to a relative outside the greater Los Angeles area and commuting to Handcraft was impractical and the other was released to his wife and he then wanted to completely dissociate himself from the hospital.

It had been clearly demonstrated, during the first year, that 100 per cent success could be achieved in bridging the gap between hospital and community agency. Having achieved this goal, the project staff felt it could become more flexible and allow some deviation from the original "unwritten contract" which patients made on entering the project.

POST HOSPITAL RESIDENCE

As previously mentioned, the preferred post-hospital residence was determined by need, as judged by project staff. Actual placement was markedly affected by availability of resources. Specifically, only men who had had experience in independent living were acceptable to Portals; referrals to family care were limited to those who needed continued supervision in a family like atmosphere; the Cinema Hotel, a small commercial hotel in Hollywood, was used primarily because it was available when needed and offered a resource which could be utilized when the patient was considered ready to leave the hospital.

Approximately one-third of the patients went to Portals and another third to the Cinema Hotel. One-fourth were placed in family care homes and the few "others" included two who returned to a family situation and three who went to other hotels.

Although our figures show that there is a differential relationship between post-hospital residence and level of success, one should be cautious in ascribing a cause and effect relationship, since assignments to type of residence were not randomized.

TABLE VIII

FIRST POST-HOSPITAL RESIDENCE AND SUCCESS LEVEL

	Level I	Level II	Level III
Portals House	28	23 (82%)	14 (61%)
		5	9
Cinema Hotel	31	23 (74%)	9 (39%)
		8	14
Family Care	21	13 (62%)	7 (54%)
		8	6
Other	5	4 (80%)	1 (25%)
		1	3
TOTAL	85	63 (74%)	31 (48%)

Regardless of post-hospital residence, three out of four subjects remained in the community for six months or longer. However, there were differences worth noting in the proportion of clients who became self-supporting. Exactly half of all project patients who entered The Portals reached Level III, while only a third of the family care clients and somewhat less than a third of the Cinema residents achieved this level. It should be remembered that The Portals accepted only those who had an independent living experience and, therefore, presumably, a better prognosis for achieving success on Level III.

Of the 47 patients who entered the project during the first year and subsequently entered the community, 16 were placed in family care homes and an equal number at the Cinema Hotel. Another 13 were placed at the Portals. However, of the 38 later admissions who subsequently left the hospital, 15 went to Portals and an equal number to the Cinema Hotel but only five entered family care homes. Data presented elsewhere in this report shows that more difficult patients were admitted after the first year. A larger portion of these later admissions were judged in need of family care and were referred for such services. Unfortunately, homes within reasonable commutation distances of Handcraft were not available when needed.

TABLE IX

POST-HOSPITAL RESIDENCE AND YEAR OF ADMISSION

	First Year	After First Year	Total
Portals	13	15	28
Cinema	16	15	31
Family Care	16	5	21
Other	2	3	5
TOTAL	47	38	85

FIRST YEAR ADMISSIONS COMPARED WITH LATER ADMISSIONS

During the first year of the project, patients were selected in accordance with the originally stated intake criteria. Considerable success was experienced in the efforts to get the first project patients into the community. As this was not a controlled research project, staff felt free in the second year to accept patients with longer periods of hospitalization and those who had various complications in their past lives which would have excluded them if the original criteria had been maintained. We have already examined the data for the total population. Now we will examine the data concerning those who were admitted during the first year compared with those who were admitted subsequently to determine whether we did, in fact, admit a differing population during the later period and examine their experiences.

The first patient was admitted to the project on August 5, 1963. The last patient included during the first year was admitted on August 3, 1964. Sixty-one patients, 43% of the total, were admitted during this first year, compared with 81, 57% of the total, who were admitted subsequently. Of the 61 first-year admissions, 47 (77%) left the hospital while on the project, while 38 (47%) of the 81 admissions during the later period left the hospital (while on the project). These figures clearly demonstrate that we were achieving a high degree of first-level success the first year and were not nearly as successful with the subjects admitted after the first year, suggesting that they were, in fact, a more difficult group.

Now, if we focus our attention on those patients who left the hospital, we do not find any remarkable differences between the first year and later admissions insofar as community tenure and self-support are concerned. With respect to second level success, a six month community tenure, 36 of the 47 patients in the first year, or 77%, achieved this level. Twenty-seven of the 38 patients, later admissions, or 71%, remained in the community for six months or longer.

A similar picture is presented for the third level success. Exactly 50% of the 36 second-level success patients from the first year became self-supporting while the other 50% did not. This is not appreciably different from the 48% of the 27 patients in the second year who became self-supporting.

The general conclusion thus far is that by taking in more difficult cases, the project did, in fact, reduce the proportion of those patients who could be helped to leave the hospital. However, it is just as clear that of those who did get out, about the same proportion remained out of the hospital six months and about the same proportion became self-supporting.

The characteristics of the first year admissions compared with the later admissions show that there are substantial differences between these two groups. With respect to age, the later admissions tended to be older. The percentages for the first year compared with the after first-year are as follows: younger - 39% and 23%; medium age - 33% and 38%; older age group - 28% and 38%. Thus, after the first year there is about the same proportion of middle age range patients (between 23 and 30 years of age) and fewer younger patients and more older patients.

Educational level was not considered in the selection of patients at any time during the life of the project. It did develop, however, that the first year admissions had a larger proportion with only grade school education and a smaller proportion with some college education than did the later group.

There is a marked difference in the proportion of patients who had any significant work history. Forty-four per cent of the first year admissions had such work history, compared with only 25% of the later admissions. This is particularly significant when one considers the fact that the second year population was older and had a greater opportunity, therefore, to have had some work history. This finding strongly suggests that we were successful in actually getting more difficult patients into the project after the first year.

The finding is not as clear with respect to independent living at the time of admission into the hospital. Twenty-eight per cent of the first year and 37% of the later admissions were living independently. This, too, may be related to the age difference. Living independently, however, does not mean that they were self-supporting. Very few of our total population had been self-supporting in the period preceding their hospitalization.

With respect to duration of hospitalization, we have already observed that medium duration of hospitalization (13 through 36 months) is associated, overall, with success in the project. The first year admissions had a much larger proportion of patients in this middle range duration of hospitalization; namely 41% compared to 30% after the first year. The trend is for the later group to have a slightly larger proportion of short hospitalizations and a slightly larger proportion of long hospitalizations.

The later admissions to the project spent a shorter time in the bakery than did the first year admissions. This applied also to the patients in the later group who left the hospital. They were in the bakery a shorter time and in Handcraft a shorter period than the first year admissions who got out of the hospital. Nevertheless, as reported above, they achieved about the same proportion of success on levels II and III. We are unable to interpret this finding. The entire question of the optimum duration of a work adjustment experience for this group of patients should be examined.

TURNAROUNDS

There were 14 patients who were "turned around" and given a second, and in some cases a third and a fourth, opportunity in the community. Of these, six were returned to the hospital after a second period in the community, while eight were "successful" to the extent of still being in the community at the time this data was gathered. Of these eight, three, in fact, achieved Level III "success" on their second trial in the community. These three are not included in the statistics which are presented. The remaining five had not had a chance to be out six months

on their second placement at the time of the gathering of the data.

Six subjects were given a third opportunity to re-enter the community. Only one of these remained out of the hospital more than two months.

The fact that the statistics in this report are based on first separation from the hospital does not mean that we believe that schizophrenic patients should be given only one opportunity to re-enter the community. Our experience rather suggests that a considerable degree of success can be attained on a second trial by some patients who fail on the first opportunity. In our very limited experience there seems to be a small likelihood of success on a third attempt within a relatively short period of time.

V. CASE ILLUSTRATIONS

In the following section, we present two case illustrations which are used because they give an opportunity to see in concrete individual experiences some of the difficulties and problems presented by the project patients as well as some of the experiences which the patients faced while in the project. These illustrations are not case histories presenting the entire life experience of the patient and the interrelationships between work and mental illness, such as are presented in the eight case studies of Simmons (12). They are not presented as evidence of "success" of the project. It is hoped they will make more real the people who comprise the "N" of this report.

CASE A

A was first hospitalized in March 1962. On admission to the project he was a 25 year old, single man diagnosed as Schizophrenic Reaction, Paranoid Type. He and his identical twin brother were born and reared in the South, received a high school education, and both claim to have had some college. Neither had worked for any significant period of time and both were supported by their parents. They were accepted into this project after being hospitalized for nearly two years.

A was in the bakery for nearly four months where his behavior was characterized by a constant presentation of delusional materials and grandiose ideas. Counseling focused on his delusional material.

When ready to leave the hospital, he was given a loan by the Jewish Free Loan Association, was moved by the project into the Cinema Hotel and started work at Handcraft. There his production was slightly below competitive rates, but he was able to relate to others without exposing his delusional thinking. Counseling at Handcraft and in the weekly group meetings stressed the development of appropriate habits of social living. Role playing was used to prepare him for job interviews.

A was considered ready to leave Handcraft to enter competitive employment after three months. He was referred to the Jewish Vocational Service placement counselor and was also encouraged and helped to seek his own employment. During the first two months after leaving Handcraft, he quit or was fired from a series of six jobs. He felt that most of the jobs he was able to obtain, such as dishwashing and clean-up work, were beneath him. However, he did manifest motivation for work and he was referred to the State Division of Vocational Rehabilitation.

As a result of his unsuccessful attempts at holding a job, he began to feel that public welfare would be the easiest alternative, particularly since his twin, having been judged to be unemployable, was receiving county welfare. It was felt that if placed on public assistance, A would lose his limited motivation for work and would accept a dependent way of life. Counseling concentrated on helping him maintain his motivation for work and on understanding better his unsatisfactory job experiences. An interim part-time job was found for him so that he could support himself without county welfare. Efforts were continued to find a full-time job and he was referred to a full-time opening as a shipping clerk following role-playing and counseling designed to help him handle appropriately the job interview. He was hired and performed well for several months.

After A was in the community for over a year and the research follow-up had been completed, the hotel manager informed the project staff that A was "acting crazy". Even though A was technically no longer officially in the study, a project staff member went to his assistance. It was found that A had consumed a large amount of tranquilizers and was unconscious.

After intensive treatment in the hospital, including another period in the bakery, A was "turned-around" and returned to the community under the auspices of the project. He returned to his former position and at the time of writing was living independently from his brother.

CASE B

On admission to the project, B was a 30 year old, single man with a diagnosis of Schizophrenic Reaction, Residual Type. He has a history of hospitalization totaling some nine years at various institutions. He completed two years of college and was essentially without a work history.

Prior to this man's hospitalization in 1955, he had been treated in sanitaria and had had private therapy. His illness began when he quit school and became moody, depressed, irritable and forgetful. Following this, he was involved in a serious auto accident which resulted in damage to his frontal lobes. He was unconscious for at least 24 hours and subsequently was committed to a state hospital. Subsequently, in 1959, he was transferred to this hospital.

Treatment had consisted of medication and electric shock treatment. He was never productive in his industrial therapy assignments during hospitalization. His progress vacillated between more or less stable remissions from complaints about hearing voices to complete apathy and withdrawal.

The project accepted B for an evaluation of work potential and to see if he could live away from an institution and work in the community.

He was in the bakery for almost three months. During this experience he was very dependent, somewhat paranoid, and showed poor judgement and short attention span. He engaged in pseudo-philosophical thinking. In spite of his difficulties, the staff felt he, perhaps, was ready to leave the hospital and live in the community. Although a family care home would have been preferred, it was not available and he was referred to the Portals House for Men. He entered Handcraft where he was not productive and constantly interrupted others and expressed his fear through such remarks as, "Am I fast enough. . . Please don't blame me too much. . . Don't hit me." After two weeks at Handcraft, he made a suicidal gesture by super-

ficially cutting his wrists and arms.

B was immediately returned to the hospital. He agreed that his suicidal gesture was his way of telling people he wanted to return to the hospital. However, he chose to continue to work in the project.

Individual counseling had as its goal to help the patient re-enter the community. After almost nine months of working in the bakery, combined with his hospital treatment program, B felt he was ready to leave the hospital. During this period he received a letter from his father advising that he should stay in the hospital for the remainder of his life. However, B began to question this advice. After leaving the hospital and returning to Handcraft, he was able to control expressing many of his inappropriate remarks and pseudo-philosophical ideas, as well as his fantasy and delusional material. However, his productivity was only at 50% of industrial standards. It became clear that he was probably not employable and could make only a marginal adjustment to the community.

At the time of his second departure from the hospital, a family care setting was not possible due to his suicidal attempts. There were no vacancies at Portals. Consequently, B was moved to the Cinema Hotel with a roommate as this was the only possible alternative aside from remaining in the hospital. His personal funds, plus his earnings at Handcraft, enabled him to exist independently for the two months he was at Handcraft. Since employment was not feasible, he was referred to the Los Angeles County Bureau of Public Assistance.

At the time of this writing, B has been residing in the hotel for over eighteen months and has been occupying his time constructively by attending various adult school classes, libraries and movies. Even though the primary goal of self-support was not achieved, it was felt that the hospital and workshop experience had a considerable influence in helping him to 1) learn to control his inappropriate verbal behavior, 2) utilize his time constructively and 3) increase his motivation and self-confidence for living in the community.

VI EVALUATION AND CONCLUSIONS

At this point it might be well to summarize the goals of the project and some of its basic accomplishments. From this, perhaps, we can draw certain conclusions as to how the experiences of the project can be utilized in enhancing the vocational rehabilitation of post-mental hospital patients.

This project, "Coordinating Hospital and Community Work Adjustment Services", was developed to meet the needs of certain hospitalized patients to help them return to and cope with work problems in the community. Many mental patients have a most unsatisfactory employment history prior to hospitalization. Their social withdrawal is intensified as a result of a whole variety of hospital experiences commonly subsumed under the term "institutionalization". Although many patients work in hospital industries, their work generally makes few demands upon them and does not prepare them adequately for coping with employment requirements in the community.

The goals of the project in the broadest terms are two: first, the conversion of a particular hospital industry into a realistic work adjustment setting. The industry selected was the bakery which prepares all the bread, rolls, cookies, etc. for 5,000 patients and many employees: second, the development of an effective relationship between a large state hospital and an independent, well-established workshop in the patient's home community.

It was clearly demonstrated by this project that monetary payment is not the only form of motivation that can be used with mental hospital patients. The promise and anticipation of leaving the hospital with a place to stay and a place to work, can serve as an effective motivating factor. Motivation also is developed through relationship. When the hospital employee shows an interest in the patient as a person, not merely as a helper, the patient's motivation to work is enhanced, if only because he wants to please the employee.

Another finding is the importance of the support given to the work program by ward personnel who are not directly concerned with the work program. From this it follows that patients occupied in the same work program should be living on the same unit rather than in widely scattered units. The support that the aides on a unit can give to patients in a vocational rehabilitation program can materially enhance the chances for success in such a program.

One of the disappointments of the project is that there appears to have been little permanent change in the functioning of the bakery in relation to patient details since the project was concluded. When project personnel were withdrawn from the bakery, it reverted to its former mode of functioning in regard to patients' work assignments and the relationship of the bakers to the patients. Perhaps what is needed as a start is a "position statement" from top and middle administration of the hospital, indicating support for the kind of work adjustment program that was developed during the bakery project. Such a statement should make it clear that patients' work in the hospital is designed for the patients' rehabilitation and not for the comfort of the employees or for the convenience of the hospital. Perhaps one way of implementing such a concept would be to develop a system of rewards for hospital employees which recognizes their accomplishments in the rehabilitation of patients. Specifically, recognition could be given to line personnel for successful rehabilitation that has been accomplished in various hospital industries and publicity can be given to some of the work that employees have done in this area.

It is suggested that line personnel, particularly those from the units, would benefit from a better understanding of the hospital industries in which patients work and conversely employees from the various hospital industries would certainly benefit from knowing more about the living areas from which their work details come. When new personnel are oriented to the program of the hospital, part of the orientation should be devoted to rehabilitation concepts and to the personnel's role in implementing these concepts. Perhaps a method can be

developed by which personnel are evaluated not only in terms of production and the other usual areas of evaluation but in addition might include the personnel's contribution to the rehabilitation of patients assigned to their work areas.

One price that administration must be ready to pay, if work assignments are to be utilized properly for vocational adjustment purposes, is the acceptance of occasional lowered production which may result when emphasis is given to rehabilitation and the needs and best interest of the patient. It will be necessary for administration to make some adjustments, particularly at times of crises, so that personnel can feel free to choose rehabilitation goals over production requirements. We recognize that ultimately the hospital may have to be staffed with an adequate complement of non-patient labor to assure that production needs are met without detracting from the rehabilitation of the patient-workers.

Our experience suggests that to speak of vocational rehabilitation by itself is an artificial separation of the vocational from the total rehabilitation needs of handicapped individuals. We have learned that, both within the hospital and, particularly, in the immediate post-hospital period, there is need for a great deal of support to enable the long-term schizophrenic patient to live in the normal community.

It is obvious out of our experience in the project, as it has been clear to others working with this group, that they need a variety of services to maintain themselves in the community. The availability of these services has a profound effect on the vocational adjustment of the post-mental hospital patient. Housing, medical care, recreational and social activity all must be available if he is to make an adequate vocational adjustment. The importance of these aspects of living are recognized for the non-disturbed citizen in the community. Their availability for the former patient assumes even greater significance. Related to this, is the problem of helping this group learn how to use existing services. In this regard we would suggest that it is important for agencies to make their services available easily for

post-mental hospital patients. Intake processes, waiting lists, schedules, all might be reviewed to determine whether what has been established for administrative convenience has the effect of establishing a barrier between the agency and those who most need its services.

The project points to the need for developing ways of providing patients with opportunities to learn the general skills of social living. While some of these skills may be developed in the work setting, it is probable that they may be more effectively learned outside of the work setting. It might be valuable to think in terms of special living units for patients needing to learn these skills, who are being helped to prepare themselves to leave the hospital. Here attention can be focussed on the skills required for living in a conventional house or apartment. In this hospital, as in others throughout the country, there is a trend for employees to live away from the hospital rather than in state-supplied housing on the institution grounds. This, then, is freeing these conventional housing accomodations which would lend themselves quite adequately for use as "exit houses". Such training centers in social living already exist in this country attached to or operated by institutions for the retarded to train retardates about to re-enter the community.

The purpose of a demonstration project is to show how something can be done either for the first time or how it can be done better in the future than it has been done in the past. One of the main jobs of the project was the conversion of an existing hospital industry into a realistic work adjustment setting. This report describes how the change was accomplished. In one sense the report is the final product of the project. However, no one is really satisfied with producing a report for the files. The intent is to have the demonstrated ways serve as a model or guide to improve practices on a larger scale. To some extent, we feel this goal has been accomplished, too.

Since this project has been completed, a comprehensive Vocational Rehabilitation Program has been established at Camarillo State Hospital through a cooperative agreement between the California Department of Rehabilitation

and the California Department of Mental Hygiene. Mr. Herbert Richert, our project supervisor from July 1, 1963 when the project went into operation , was hired to begin work January 1, 1966 by the Department of Rehabilitation to develop the cooperative program between the two departments and then to serve as program supervisor. It may be assumed that he was hired because of his personal qualifications and particularly because his experience in "the bakery project" uniquely qualified him to apply our methods and findings on a larger scale.

The introduction to the cooperative agreement gives the background for the new program. It includes a description of "the bakery project" and its findings as given in the second progress report. The introduction concludes with the following statement regarding our project, "The success of this program clearly demonstrates the feasibility of the use of vocational rehabilitation techniques in the treatment of chronic mentally ill patients." The greatly expanded Vocational Rehabilitation program, recently initiated at the hospital, is in part an outgrowth of "the bakery project".

REFERENCES

1. Joint Commission on Mental Illness and Health. Action for Mental Health. New York: Basic Books, 1961.

2. LUSTIG, Paul. A study of the contribution of workshop experience in the vocational rehabilitation of post-hospitalized schizophrenic patients. Final Report. V.R.A. Project No. 33459. October, 1963.

3. WILLIAMS, Richard H. (ed.) The prevention of disability in mental illness. (Mental Health Monograph No. 1.) Washington, D.C., National Institute of Mental Health. 1962.

4. MOES, J. Howard. VR workshop attacks psychological barriers. Journal of Rehabilitation. March-April, 1962.

5. MEYER, H. J. and E. F. Borgatta. An experiment in mental patient rehabilitation: Evaluating a social agency program. New York, Russell Sage Foundation. 1959.

6. GOFFMAN, Erving. Characteristics of total institutions. In Symposium on preventive and social psychiatry. Washington, D.C., Walter Reed Institute of Research, 1957.

7. GOERTZEL, Victor and Morris Grumer. Joint operation--a philosophy of inter-agency relationship. Journal of Jewish Communal Service, Vol. 41, No. 3, 1965.

8. GELLMAN, William, et al. Adjusting people to work. 2d ed. Chicago, Illinois, Jewish Vocational Service, 1957.

9. MOES, J. Howard. Op. cit.

10. VARGAS, M. James and Victor Goertzel. Medication continuity in patients leaving a state mental hospital. California Mental Health Research Digest, Vol. 1, No. 4, 1963.

11. VITALE, John H. and Joseph M. McDonough. The sheltered workshop--an experimental study with chronic mental patients. Mental Hygiene. Vol. 50, No. 2, April 1966.

12. SIMMONS, Ozzie G. Work and Mental Illness. New York, John Wiley, 1965.

APPENDIX

PROFESSIONAL ACTIVITIES

The following presentations related to the project were made at professional meetings: publications are indicated.

V. Goertzel organized and chaired a symposium entitled "Work therapy as a rehabilitation technique for N.P. hospital patients" at the annual meeting of the Western Psychological Association, Portland, April 1964. Included were the following papers by project staff: E. G. Thompson "Counseling hospitalized schizophrenic patients in a work setting", H. Richert "Modifying an existing hospital industry".

V. Goertzel and M. Grumer, "Joint operation - a philosophy of inter-agency relationships" National Conference of Jewish Communal Services, Los Angeles, June 1964, (Jewish Social Service Quarterly, Vol. 41: No. 3, 1965).

V. Goertzel organized and chaired a symposium entitled "The role of work in the rehabilitation of mental patients" at the annual meeting of the American Psychological Association, Los Angeles, September 1964. At the same meetings, in a symposium on "Approaches to psychiatric rehabilitation" chaired by W. S. Neff, he presented a paper on "Evaluation of halfway house programs". (Quarterly of Camarillo, Vol. 1, No. 3, 1965.)

M. Grumer was a discussant at a V.R.A. conference on "Work adjustment settings", Chicago, November 1964.

A summary of this project's first progress report by V. Goertzel and H. Richert appeared in the California Mental Health Research Digest, Vol. 2: No. 3, 1964.

A summary of the second progress report was published in the same Digest, Vol. 3, No. 2, 1965.

Additional presentations and publications are anticipated following the completion of this final report.